

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH  
County Somerset

814

28

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 268

Village or City Deals Island (No. 135)

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Lillie May Austin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

Nov 7, 1900  
(Month) (Day) (Year)

7 AGE

14 yrs. 1 mos. 27 ds.If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of workSchool Girl(b) General nature of industry,  
business, or establishment in  
which employed (or employer)—

9 BIRTHPLACE

(State or country)

Somerset Co.

PARENTS

10 NAME OF  
FATHERWesley Austin11 BIRTHPLACE  
OF FATHER  
(State or country)Somerset Co.12 MAIDEN NAME  
OF MOTHERLillie Webster13 BIRTHPLACE  
OF MOTHER  
(State or country)Somerset Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lillie Austin

(Address)

Deals Island Md.

15

Filed Jan 4, 1914

Geo. W. Horner

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 3rd

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec 15, 1913 to Jan 3rd, 1914that I last saw her alive on Jan. 2nd, 1914and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
 (Duration) 3 months  
9 Septenia (Duration) — yrs. — mos. — ds.  
 Contributory Secondary

(Signed) H.G. Alexander, M.D.  
 (Address) Deals Island  
 Jan 4, 1914

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Deals Island Md. DATE OF BURIAL Jan 4, 1914

20 UNDERTAKER

Ted Gentry ADDRESS Deals Island Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc. when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 3 1914

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Somerset

815

Village or City Westover (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 364

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Lettie May Benson (Benson)

## PERSONAL AND STATISTICAL PARTICULARS

|        |                 |  |
|--------|-----------------|--|
| 3 SEX  | 4 COLOR OR RACE | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word) |
| female | colored         | Single   |

|                 |             |                       |
|-----------------|-------------|-----------------------|
| 6 DATE OF BIRTH | Dec.<br>Jan | 30th. 1913<br>5, 1914 |
|                 | (Month)     | (Day)<br>(Year)       |

|                         |    |  |
|-------------------------|----|--|
| 7 AGE                   | 19 | If LESS than<br>1 day, . . . hrs.<br>OR min. ? |
| yrs. .... mos. .... ds. | 13 |  |

|  |      |
|--|------|
| 8 OCCUPATION   | none |
| (a) Trade, profession, or particular kind of work  |      |
| (b) General nature of industry, business, or establishment in which employed (or employer) |      |

|                                    |             |
|------------------------------------|-------------|
| 9 BIRTHPLACE<br>(State or country) | Somerset Co |
|------------------------------------|-------------|

|                   |               |
|-------------------|---------------|
| 10 NAME OF FATHER | Joshua Benson |
|-------------------|---------------|

|   |              |
|---|--------------|
| 11 BIRTHPLACE OF FATHER<br>(State or country) | Somerset Co. |
|---|--------------|

|                          |                |
|--------------------------|----------------|
| 12 MAIDEN NAME OF MOTHER | Laura Walloppe |
|--------------------------|----------------|

|   |             |
|---|-------------|
| 13 BIRTHPLACE OF MOTHER<br>(State or country) | Somerset Co |
|---|-------------|

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joshua Benson

(Address) Westover Md.

15 Filed Jan 18th, 1914 G. E. Dickinson  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 18, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on 191 . . . , 191 . . .

and that death occurred on the date stated above, at 5 A.m.

The CAUSE OF DEATH\* was as follows:

Probably Bronchopneumonia

I did not see the case  
(Duration) yrs. mos. one ds.

Contributory  
Secondary  
(Duration) yrs. mos. ds.

(Signed) G. W. Gill, M.D.

Jan 18, 1914 (Address) Maryland Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Westover DATE OF BURIAL Jan 19, 1914

20 UNDERTAKER Herbert Wilson Weller & Son

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæsthesia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicac-  
mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tenuus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

|              |  |
|--------------|--|
| RECEIVED     |  |
| FEB 4 1914   |  |
| BUREAU. V.S. |  |

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V. S. No. 1.

|  |                 |  |
|--|-----------------|--|
| 1 PLACE OF DEATH   |                 | 816  |
| County   |                 | Somerset   |
| Village or City  |                 | Princess Anne  |
| 2 FULL NAME  |                 | Hester Buckhead  |
| PERSONAL AND STATISTICAL PARTICULARS   |                 |  |
| 3 SEX  | 4 COLOR OR RACE | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word) |
| Female   | Colored         | Married  |
| 6 DATE OF BIRTH  |                 | Sept 14, 1864  |
|  |                 | (Month) (Day) (Year)   |
| 7 AGE  |                 | 49 yrs. 5 mos. 16 ds.  |
|  |                 | If LESS than<br>1 day, hrs.<br>OR min. ?                             |
| 8 OCCUPATION<br>(a) Trade, profession, or<br>particular kind of work                             |                 |  |
| (b) General nature of industry,<br>business, or establishment in<br>which employed (or employer) |                 |  |
| 9 BIRTHPLACE<br>(State or country)   |                 |  |
| 10 NAME OF FATHER  |                 |  |
| Robert Anderson  |                 |  |
| 11 BIRTHPLACE OF FATHER<br>(State or country)  |                 |  |
| Maryland   |                 |  |
| 12 MAIDEN NAME OF MOTHER   |                 |  |
| Melvina Williams   |                 |  |
| 13 BIRTHPLACE OF MOTHER<br>(State or country)  |                 |  |
| Maryland   |                 |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE   |                 |  |
| (Informant) John Buckhead  |                 |  |
| (Address) Princess Anne Md   |                 |  |
| 15   | Filed 131       | 1914 J. G. Smith   |
| REGISTRAR  |                 |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 76

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 30, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 5, 1914, to Jan 30, 1914,  
that I last saw her alive on Jan 28, 1914,

and that death occurred on the date stated above, at 10, 15 P.M.

The CAUSE OF DEATH\* was as follows:

Double emphysema of  
lungs & heart

(Duration) yrs. 1 mos. ds.

Contributory  
Secondary

Henry M. Lankford, M.D.  
(Signed) Jan 31, 1914 (Address) Princess Anne

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Princess Anne 7/1/14

20 UNDERTAKER ADDRESS

John Jones Baltimore

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

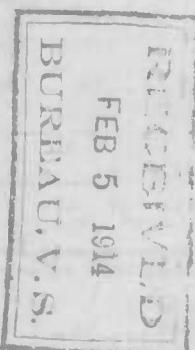
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croupy"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcinoma*,

o<sup>m</sup>a, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ictanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH  
County Somerset

817

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 261

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Mary (No.)

## 2 FULL NAME

Thos. Franklin Bradshaw

## PERSONAL AND STATISTICAL PARTICULARS

|                   |                              |   |
|-------------------|------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the words) |
|-------------------|------------------------------|---|

## 6 DATE OF BIRTH

12 - 5 - 1914  
(Month) (Day) (Year)

## 7 AGE

yrs. 1 mos. 12 ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work \_\_\_\_\_  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country)Md10 NAME OF  
FATHERJ.W. Bradshaw11 BIRTHPLACE  
OF FATHER  
(State or country)Md12 MAIDEN NAME  
OF MOTHERHorma Tull13 BIRTHPLACE  
OF MOTHER  
(State or country)Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W.R. Bradshaw

(Address)

Kingston

15

Filed

191

F.J. Adams

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

1 - 17, 1914  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

....., 191..... to ..... 191.....

that I last saw h..... alive on ..... 191.....

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH\* was as follows:

Whooping cough  
Found dead in bed

No d. in attendance (Duration) yrs. mos. ds.

Contributory  
Secondary

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
if not at place of death?  
Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

St Pauls Cemetery

DATE OF BURIAL

1 - 19, 1914

## 20 UNDERTAKER

C. W. Dillan

ADDRESS

Mary

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cat wife*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houscark*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ictanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1914

BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

**1 PLACE OF DEATH**  
County Somerset

818

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 266St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Tylerston (No.)**2 FULL NAME**John F. Bruce

## PERSONAL AND STATISTICAL PARTICULARS

**3 SEX**m**4 COLOR OR RACE**W.**5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED**  
(Write the word)**6 DATE OF BIRTH**Jan. 30, 1914

(Month)

(Day)

(Year)

**7 AGE**

yrs.

mos.

ds.

If LESS than  
1 day.....hrs.  
OR min.?**8 OCCUPATION**(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)**9 BIRTHPLACE**  
(State or country)Tylerston, Ind.**10 NAME OF  
FATHER**John F. Bruce**11 BIRTHPLACE  
OF FATHER**  
(State or country)New York City**12 MAIDEN NAME  
OF MOTHER**Jessie Marshall**13 BIRTHPLACE  
OF MOTHER**  
(State or country)Tylerston**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**Informant) John F. Bruce

15

Filed.....191.....

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH**Jan. 30, 1914

(Month)

(Day)

(Year)

**17 I HEREBY CERTIFY, That I attended deceased from**Jan. 30, 1914 to Jan. 30, 1914that I last saw him alive on Jan. 30, 1914 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Asphyxia neocortorum

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Celia J. Schwartz M. D.Jan. 31, 1914 (Address) Well

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL**Tylerston Jan. 30, 1914**20 UNDERTAKER**A. B. Bradshaw ADDRESS Well

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—Coal mining, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc.; *Carcin-*

oma

"Sarcoma, etc., of ..... (name origin; "Cap-  
ver" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital"), "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|               |
|---------------|
| RECEIVED      |
| FEB 6 1914    |
| BUREAU, V. S. |

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

819

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 265Village or City Crisfield

(No.)

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nancy Byrd

## PERSONAL AND STATISTICAL PARTICULARS

|                                |   |  |
|--------------------------------|---|--|
| <sup>3</sup> SEX <u>Female</u> | <sup>4</sup> COLOR OR RACE <u>negro</u> | <sup>5</sup> STONE,<br><u>MARRIED,</u><br><u>WIDOWED,</u><br><u>BACHELOR,</u><br>(Write the word) <u>widowed</u> |
|--------------------------------|---|--|

<sup>6</sup> DATE OF BIRTH Unknown, 1  
(Month) (Day) (Year)

|  |  |          |
|--|--|----------|
| <sup>7</sup> AGE <u>About</u><br><u>61</u> | If LESS than<br>1 day, <u>hrs.</u><br>OR <u>min. ?</u> |          |
| YRS. ....                                  | MOS. ....  | ds. .... |

|  |                  |
|--|------------------|
| <sup>8</sup> OCCUPATION<br>(a) Trade, profession, or<br>particular kind of work.<br><br>(b) General nature of industry,<br>business, or establishment in<br>which employed (or employer) <u>Domestic</u> | <u>Housework</u> |
|--|------------------|

|  |
|--|
| <sup>9</sup> BIRTHPLACE<br>(State or country) <u>Md.</u> |
|--|

|  |
|--|
| <sup>10</sup> NAME OF<br>FATHER <u>Unknown</u> |
|--|

|  |
|--|
| <sup>11</sup> BIRTHPLACE<br>OF FATHER<br>(State or country) <u>Unknown</u> |
|--|

|   |
|---|
| <sup>12</sup> MAIDEN NAME<br>OF MOTHER <u>Unknown</u> |
|---|

|  |
|--|
| <sup>13</sup> BIRTHPLACE<br>OF MOTHER<br>(State or country) <u>Unknown</u> |
|--|

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Jones

(Address) Lawsonia, Md.

15 Filed Jan 28, 1914 by Collins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH Jan. 26, 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1914 to Jan. 26, 1914,  
that I last saw her alive on Jan. 26, 1914,  
and that death occurred on the date stated above, at 4 P.M.  
The CAUSE OF DEATH\* was as follows:

La grippe

(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Signed) W. J. Barkley, M. D.  
Jan. 27, 1914 (Address) 309 W. 5th Ave.

\* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Lawsonia DATE OF BURIAL Jan 28, 1914

<sup>20</sup> UNDERTAKER R. J. Collins ADDRESS Crisfield

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Confusional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
FEB 3 1914  
BUREAU, U.S.

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|   |   |   |   |                                    |   |
|---|---|---|---|------------------------------------|---|
| 1 PLACE OF DEATH<br>County..... <i>Worcester</i>  |   | 820   | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |                                    |   |
| Village or City <i>Upper Fairmount</i> (No.)  |   |   | St:..... <i>Ward</i> )                    | Registration Dist. No. <i>264</i>  |   |
| <i>Hester Jane Battin</i>   |   |   |   |                                    |   |
| 2 FULL NAME   |   |   |   |                                    |   |
| PERSONAL AND STATISTICAL PARTICULARS  |   |   |   |                                    |   |
| 3 SEX<br><i>female</i>  | 4 COLOR OR RACE<br><i>White</i>   | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word)<br><i>Wedded</i> | MEDICAL CERTIFICATE OF DEATH              |                                    |   |
| 6 DATE OF BIRTH<br><i>1883 May 25</i>   | X (Month)   | X (Day)   | X (Year)                                  | 16 DATE OF DEATH<br><i>Jan. 24</i> | , 1914<br>(Month) (Day) (Year)                |
| 7 AGE <i>81</i>   | <i>7 months</i>   | yrs.  | mos.                                      | ds.                                | if LESS than<br>1 day, .... hrs.<br>OR min. ? |
| 8 OCCUPATION<br>(a) Trade, profession, or<br>particular kind of work.<br><i>House Work</i>  | 17 I HEREBY CERTIFY, That I attended deceased from<br><i>December 1913</i> to <i>January 1914</i><br>that I last saw her alive on <i>December 1913</i><br>and that death occurred on the date stated above, at <i>3 P.M.</i><br>The CAUSE OF DEATH* was as follows: |   |   |                                    |   |
| 9 BIRTHPLACE<br>(State or country)<br><i>Worcester County</i>                               | <i>Cancer of the Throat</i>   |   |   |                                    |   |
| 10 NAME OF<br>FATHER<br><i>Peter Townsend</i>   | (Duration) <i>3</i> yrs. — mos. — ds.   |   |   |                                    |   |
| 11 BIRTHPLACE<br>OF FATHER<br>(State or country)<br><i>Worcester County</i>                 | Contributory<br>(Secondary)<br><i>E.S. Miles</i> , M.D.   |   |   |                                    |   |
| 12 MAIDEN NAME<br>OF MOTHER<br><i>Mary Anne Battin</i>                                      | (Duration) <i>Jan. 24</i> , 1914 (Address) <i>Upper Fairmount</i>   |   |   |                                    |   |
| 13 BIRTHPLACE<br>OF MOTHER<br>(State or country)<br><i>Worcester County</i>                 | * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT<br>CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-<br>DENTAL, SUICIDAL, or HOMICIDAL   |   |   |                                    |   |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant)<br><i>Frederick Berrell</i> | 16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,<br>OR RECENT RESIDENTS)  |   |   |                                    |   |
| (Address)<br><i>Upper Fairmount</i>   | At place of death yrs. mos. ds. In the State yrs. mos. ds.  |   |   |                                    |   |
| 15 Filed <i>Jan. 26</i> , 1914  | Where was disease contracted, if not at place of death?   |   |   |                                    |   |
| Local. REGISTRAR<br><i>H. E. Dickinson</i>  | Former or usual residence   |   |   |                                    |   |
| 19 PLACE OF BURIAL OR REMOVAL<br><i>Upper Fairmount</i>                                     | DATE OF BURIAL<br><i>Jan. 26</i> , 1914   |   |   |                                    |   |
| 20 UNDERTAKER<br><i>Jones Mortuary</i>  | ADDRESS <i>26</i>   |   |   |                                    |   |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "An-  
themia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-  
mus," "Old Age," "Shock," "Traenita," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septic-hac-  
mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-  
dental*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 4 1914

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Somerset  
Village or City Manna

821

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 261

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Felur Collins

|   |                                |
|---|--------------------------------|
| PERSONAL AND STATISTICAL PARTICULARS                                      |                                |
| 3 SEX <u>Female</u>   | 4 COLOR OR RACE <u>Colored</u> |
| 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Infant</u> |                                |

6 DATE OF BIRTH  
7 - 5 - 1913  
(Month) (Day) (Year)

7 AGE  
6 yrs. 2 mos. 1 ds. If LESS than  
1 day.....hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
   
(b) General nature of industry, business, or establishment in which employed (or employer)  
 

9 BIRTHPLACE  
(State or country) Md

10 NAME OF FATHER Geo Collins

11 BIRTHPLACE OF FATHER  
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Jackson

13 BIRTHPLACE OF MOTHER  
(State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Geo Collins

(Address) Manna

15 Filed 1/30, 1914 J J Adams

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 - 29 - 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
191 to 191,

that I last saw him alive on 191,

and that death occurred on the date stated above, at 191.

The CAUSE OF DEATH\* was as follows:

No Dr for some time  
child always sickly

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) J J Adams M. D.  
1/30, 1914 (Address) Manna

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore DATE OF BURIAL  
1 - 30 - 1914

20 UNDERTAKER Adams ADDRESS  
Manna

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

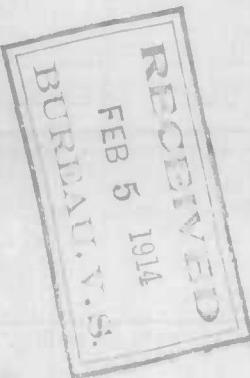
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Horsewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Epidemic cerebrospinal meningitis*); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dairy laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 8 1914  
BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

|   |                                   |  |
|---|-----------------------------------|--|
| 1 PLACE OF DEATH<br>County <i>Sussex</i>  |                                   | 823  |
| Village or City <i>Mt Vernon</i> (No.)  |                                   | <i>10</i>  |
| 2 FULL NAME <i>Amen Jack</i>  |                                   |  |
| PERSONAL AND STATISTICAL PARTICULARS  |                                   |  |
| 3 SEX<br><i>Female Colored</i>  | 4 COLOR OR RACE<br><i>Colored</i> | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word)<br><i>Widow</i> |
| 6 DATE OF BIRTH<br><i>Do not know</i>   |                                   | (Month) (Day) (Year)   |
| 7 AGE<br><i>About 80</i>  |                                   | 8 If LESS than<br>1 day, .... hrs.<br>OR ..... min. ?<br><i>None</i>                 |
| 9 OCCUPATION<br>(a) Trade, profession, or<br>particular kind of work<br><i>None</i><br>(b) General nature of industry,<br>business, or establishment in<br>which employed (or employer)<br><i>Do not know</i> |                                   |  |
| 10 BIRTHPLACE<br>(State or country)<br><i>Ned</i>   |                                   |  |
| 11 NAME OF FATHER<br><i>Sampson Jack</i>  |                                   |  |
| 12 BIRTHPLACE OF FATHER<br>(State or country)<br><i>Do not know</i>   |                                   |  |
| 13 MAIDEN NAME OF MOTHER<br><i>Do not know</i>  |                                   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <i>Myself</i><br>Address <i>Frances Ann Ned</i>   |                                   |  |
| 15 Filed <i>Jan 28 1914</i> at <i>Nothants local</i> REGISTRAR  |                                   |  |

STATE OF MARYLAND  
CERTIFICATE OF DEATH.Registration Dist. No. *263*

St: \_\_\_\_\_ Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

|  |  |                                       |
|--|--|---------------------------------------|
| MEDICAL CERTIFICATE OF DEATH   |  |                                       |
| 16 DATE OF DEATH<br><i>Jan 27, 1914</i>  |  |                                       |
| 17 I HEREBY CERTIFY, That I attended deceased from<br><i>Jan 20, 1914</i> to <i>Jan 27, 1914</i> ,<br>that I last saw him alive on <i>Jan 21, 1914</i> ,<br>and that death occurred on the date stated above, at <i>10:30 P.M.</i><br>The CAUSE OF DEATH was as follows:<br><i>In grippe</i> |  |                                       |
| (Duration) yrs. mos. ds.   |  |                                       |
| Contributory<br>(Secondary)  |  |                                       |
| (Duration) yrs. mos. ds.   |  |                                       |
| Signed <i>H. A. Barnes, M.D.</i><br>Jan 28, 1914 (Address) <i>Frances Ann Ned</i>  |  |                                       |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT<br>CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-<br>DENTAL, SUICIDAL, or HOMICIDAL.  |  |                                       |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,<br>OR RECENT RESIDENTS)<br>At place of death yrs. mos. ds. In the State yrs. mos. ds.<br>Where was disease contracted,<br>if not at place of death?<br>Former or usual residence  |  |                                       |
| 19 PLACE OF BURIAL OR REMOVAL<br><i>Mt Vernon Ned</i>  |  | DATE OF BURIAL<br><i>Jan 29, 1914</i> |
| 20 UNDERTAKER ADDRESS<br><i>Dashell Bros. Penn 2nd</i>   |  |                                       |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal minc*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*oma. *Sarcoma*, etc. of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Aatrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as accidental, suicidal, or homicidal, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train*—*accident*; *Revolver wound of head*—*homicide*; *Poisoned by carbolic acid*—*probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetomus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 4 1914

BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County *Somerset*

824

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No 261

Village or City *Marsoni* (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Baby Gale*

## PERSONAL AND STATISTICAL PARTICULARS

|                      |                               |  |
|----------------------|-------------------------------|--|
| 3 SEX<br><i>Male</i> | 4 COLOR OR RACE<br><i>Coe</i> | 5 SINGLE, male, blue eyes, brown hair,<br>MARRIED,<br>WIDOWED,<br>DIVORCED<br>(Write the word) |
|----------------------|-------------------------------|--|

6 DATE OF BIRTH

*Born Jan 31, 1914*  
(Month) (Day) (Year)

7 AGE

|           |           |          |  |
|-----------|-----------|----------|--|
| Yrs. .... | mos. .... | ds. .... | It LESS than<br>1 day, ..... hrs.<br>OR ..... min. ? |
|-----------|-----------|----------|--|

8 OCCUPATION

- (a) Trade, profession, or particular kind of work  
*Nurse*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)*Somerset Co*

10 NAME OF FATHER

*Charles Gale*11 BIRTHPLACE OF FATHER  
(State or country)*Somerset Co*

12 MAIDEN NAME OF MOTHER

*Adelma Daughler*13 BIRTHPLACE OF MOTHER  
(State or country)*Somerset Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Charles Gale*(Address) *Marsoni*

15

Filed *1/31 1914 J. P. Adams*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*Born Jan 31, 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191..... to ..... 191.....

that I last saw him alive on ..... 191.....

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH\* was as follows:

*Born Jan 31, 1914*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *George Chellon*, M. D.Jan 31, 1914 (Address) *Marsoni*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

*Ebenser* DATE OF BURIAL  
*1-31 1914*

20 UNDERTAKER

*Ad Dixon* ADDRESS  
*Marsoni*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

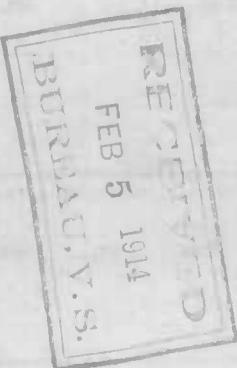
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*oma, Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*. *Poisoned by earabolic acid—probably suicide*. The nature of the injury as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|   |                                      |  |           |
|---|--------------------------------------|--|-----------|
| 1 PLACE OF DEATH<br>County  |                                      | Deal Island<br>Somerset and  | 825       |
| Village or City   |                                      | Deal Island (No. 135)  | QJ        |
| 2 FULL NAME   |                                      | Frances Louise Graham  |           |
| PERSONAL AND STATISTICAL PARTICULARS  |                                      |  |           |
| 3 SEX<br><i>Female</i>  | 4 COLOR OR RACE<br><i>White</i>      | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word)<br><i>married</i> |           |
| 6 DATE OF BIRTH<br><i>March 20, 1850</i>  |                                      | (Month)  | (Day)     |
|   |                                      | (Year)   |           |
| 7 AGE<br><i>64 yrs. 10 mos. 7 ds.</i>   |                                      | If LESS than<br>1 day, ____ hrs.<br>OR ____ min. ?                                     |           |
| 8 OCCUPATION<br>(a) Trade, profession, or<br>particular kind of work... <i>House wife</i><br>(b) General nature of industry,<br>business, or establishment in<br>which employed (or employer) |                                      |  |           |
| 9 BIRTHPLACE<br>(State or country)  |                                      | Deal Island  | md        |
| 10 NAME OF<br>FATHER  |                                      | <i>Wallace Webster</i>   |           |
| 11 BIRTHPLACE<br>OF FATHER<br>(State or country)  |                                      | md   |           |
| 12 MAIDEN NAME<br>OF MOTHER   |                                      | <i>Eliza Rowe</i>  |           |
| 13 BIRTHPLACE<br>OF MOTHER<br>(State or country)  |                                      | md   |           |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <i>John G. Graham</i><br>(Address) Deal Island md   |                                      |  |           |
| 15  | Filed <i>Jan 14 1914 Rec Bspnser</i> |  | REGISTRAR |

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 268

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *January 11th, 1914*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *January 10th to January 10th, 1914*  
that I last saw her alive on *January 10th, 1914*  
and that death occurred on the date stated above, at *2 p.m.*  
The CAUSE OF DEATH\* was as follows:

*Lieberman*  
 (Duration) — yrs. — mos. — ds.

Contributory *Health*  
Secondary

(Signed) *T.G. Alexander, M.D.*  
*Jan 14, 1914* (Address) *Deal Island*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted,  
 If not at place of death?  
 Former or  
 usual residence.

19 PLACE OF BURIAL OR REMOVAL *Deal Island md* DATE OF BURIAL *Jan 15, 1914*

20 UNDERTAKER *Geo. Gandy* ADDRESS *Deal Island*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dcaier," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc., *Carcin-*

oma

"oma, Sarcoma, etc, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uracenia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 3 1914

W. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County *Sonnet*

Village or City *Not Vernon* (No.)

2 FULL NAME *Infant*

826

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *263*St. *Ward*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

|                                      |                 |  |
|--------------------------------------|-----------------|--|
| PERSONAL AND STATISTICAL PARTICULARS |                 |  |
| 3 SEX                                | 4 COLOR OR RACE | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word) |
| Male Colored                         | Twigs           |  |

6 DATE OF BIRTH  
*Jan 19, 1914*  
(Month) (Day) (Year)

7 AGE  
*Not born*  
mos. ds.  
If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work  
*woman*  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)  
*Sonnet Co*

10 NAME OF  
FATHER  
*Sam Handley*

11 BIRTHPLACE  
OF FATHER  
(State or country)  
*Sonnet Co*

12 MAIDEN NAME  
OF MOTHER  
*Frances Hand*

13 BIRTHPLACE  
OF MOTHER  
(State or country)  
*Sonnet Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Benjamin Handley*  
(Address) *Frances Handley*

15 Filed *Jan 20 1914*  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*Jan 19, 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
....., 191... to .....

that I last saw h ..... alive on *Jan 19, 1914*

and that death occurred on the date stated above, *Jan 19, 1914*.

The CAUSE OF DEATH\* was as follows:

*Not born - before term*

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.  
(Signed) *W. A. Barnes* M. D.  
*Jan 19, 1914* (Address) *Carson's Barber Shop*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
of death yrs. mos. ds. In the  
State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL  
*Not buried*

DATE OF BURIAL  
*Jan 20, 1914*

20 UNDERTAKER  
*Rashell Bros.*

ADDRESS  
*P. Anne Inn*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*oma, *Sarcoma*, etc., or ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosches*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—*accident*; *Revolver wound of head*—*homicide*; *Poisoned by carbolic acid*—*probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 4 1914  
BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|  |  |   |
|--|--|---|
| 1 PLACE OF DEATH   |  | 827   |
| County <u>Somerset</u>   |  |   |
| Village or City <u>Leisfield</u> (No.)   |  |   |
| 2 FULL NAME <u>Tena Alice Hayward</u>  |  |   |
| PERSONAL AND STATISTICAL PARTICULARS   |  |   |
| 3 SEX <u>Female</u>  | 4 COLOR OR RACE <u>Black</u>                   | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Single</u> |
| 6 DATE OF BIRTH <u>August 24</u>   |  | (Month) (Day) (Year)  |
| 7 AGE <u>15 yrs. 4 mos. 13 ds.</u>   | If LESS than<br>1 day.....hrs.<br>OR.....min.? |   |
| 8 OCCUPATION <u>Housework</u><br>(a) Trade, profession, or particular kind of work<br>(b) General nature of Industry, business, or establishment in which employed (or employer) |  |   |
| 9 BIRTHPLACE (State or country) <u>Somerset</u>  |  |   |
| 10 NAME OF FATHER <u>Isaac Hayward</u>   |  |   |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Somerset</u>   |  |   |
| 12 MAIDEN NAME OF MOTHER <u>Milie Hayward</u>  |  |   |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Somerset</u>   |  |   |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>G. J. Simonson</u><br>(Address) <u>Leisfield Md</u>   |  |   |
| 15   | FECO. <u>Jan 10 1914</u> 680116                |   |
|  |  | REGISTRAR   |

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 265

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 7, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from Dec 25, 1913, to January 7, 1914, that I last saw her alive on Jan 3, 1914, and that death occurred on the date stated above, at 9. P. M.. The CAUSE OF DEATH\* was as follows:

Typhoid (Duration) — yrs. — mos. 15 ds.

Contributory  
Secondary Pneumonia (Duration) — yrs. — mos. 2 ds.

(Signed) G. J. Simonson M. D.  
Jan 8, 1914 (Address) Leisfield Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Asbury Colored Cemetery DATE OF BURIAL Jan. 11th 1914

20 UNDERTAKER D. J. Lawson ADDRESS Leisfield

# REVISED UNITED STATES STANDARD

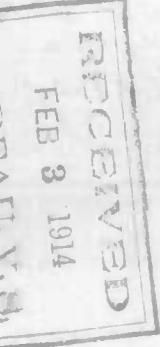
## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*oma, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Cap-  
er" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Postpartal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**1 PLACE OF DEATH**  
County Somerset

828

Village or City Tylerton (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. Heb

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** Alice H. Hoffmann

| PERSONAL AND STATISTICAL PARTICULARS   |                                     |   |              |                              |
|--|-------------------------------------|---|--------------|------------------------------|
| <b>3 SEX</b><br><u>Female</u>  | <b>4 COLOR OR RACE</b><br><u>H.</u> | <b>5 SINGLE;<br/>MARRIED,<br/>WIDOWED,<br/>DIVORCED</b><br>(Write the word) |              |                              |
| <b>6 DATE OF BIRTH</b><br><u>unknown</u>   |                                     | <b>(Month)</b>  | <b>(Day)</b> | <b>(Year)</b><br><u>1888</u> |
| <b>7 AGE</b><br><u>56</u>  |                                     | If LESS than<br>1 day, ____ hrs.<br>or ____ min. ?                          |              |                              |
|  |                                     | Yrs.  | Mos.         | ds.                          |
| <b>8 OCCUPATION</b><br>(a) Trade, profession, or particular kind of work...<br><u>Housework</u><br>(b) General nature of industry, business, or establishment to which employed (or employer)<br><u></u> |                                     |   |              |                              |
| <b>9 BIRTHPLACE</b><br>(State or country) <u>Tylerton, Md.</u>   |                                     |   |              |                              |
| <b>10 NAME OF FATHER</b><br><u>Hoffmann Evans</u>  |                                     |   |              |                              |
| <b>11 BIRTHPLACE OF FATHER</b><br>(State or country) <u>Tylerton, Md.</u>  |                                     |   |              |                              |
| <b>12 MAIDEN NAME OF MOTHER</b><br><u>Elizabeth Evans</u>  |                                     |   |              |                              |
| <b>13 BIRTHPLACE OF MOTHER</b><br>(State or country) <u>Tylerton, Md.</u>  |                                     |   |              |                              |
| <b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b>  |                                     |   |              |                              |
| Informant <u>John H. Hoffmann</u>  |                                     |   |              |                              |
| (Address) <u>Tylerton</u>  |                                     |   |              |                              |
| 15 Filed _____, 1911   |                                     |   |              |                              |
| REGISTRAR  |                                     |   |              |                              |

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH**  
Jan. 24, 1914  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1914, to Jan. 23, 1914  
that I last saw her alive on Jan. 23, 1914

and that death occurred on the date stated above, at 3 a.m.  
The CAUSE OF DEATH\* was as follows:

Chronic nephritis

(Duration) yrs. mos. ds.  
**Contributory**  
(Secondary) Arassia

(Duration) yrs. mos. ds.  
(Signed) Claess J. Schaeffer, M.D.  
Jan. 31, 1914 (Address) Gowell

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL**

Tylerton DATE OF BURIAL Jan. 25, 1914

**20 UNDERTAKER** A.B. Bradshaw ADDRESS Gowell

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc.; *Carcin-*

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oma, *Sarcoma*, etc., of (name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic voluntary heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ast-  
hma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-  
nus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Somerset

829

Village or City Morion (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 261

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel Storrey

## PERSONAL AND STATISTICAL PARTICULARS

|                   |                              |  |
|-------------------|------------------------------|--|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Black</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u><br>(Write the word) |
|-------------------|------------------------------|--|

## 6 DATE OF BIRTH

Dont Know, 1834  
(Month) (Day) (Year)

## 7 AGE

80 Dont Know  
yrs. mos. ds. It LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)  

9 BIRTHPLACE  
(State or country)Mary land

## 10 NAME OF FATHER

Lewis Storrey11 BIRTHPLACE OF FATHER  
(State or country)Mary land

## 12 MAIDEN NAME OF MOTHER

Dont know13 BIRTHPLACE OF MOTHER  
(State or country)Mary land

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cornelius Storrey(Address) Morion 2nd

15

Filed 1-28, 1914 J. J. Adams

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 28, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1914, to Jan 28 1914,

that I last saw him alive on 1-27, 1914,

and that death occurred on the date stated above, at 8 A.M.,

The CAUSE OF DEATH\* was as follows:

Paralysis & exhaustion

(Duration) yrs. mos. ds.

Contributory age  
Secondary

(Duration) yrs. mos. ds.

(Signed) J. J. Adams, M. D.

1-28, 1914 (Address) Morion 2nd

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ in the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
it not at place of death?

Former or  
usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

Library DATE OF BURIAL  
1-30, 1914

20 UNDERTAKER McGilton ADDRESS  
Morion

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

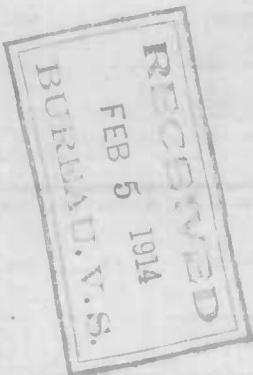
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coat lining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcin-*

oma

"ancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

|   |   |   |
|---|---|---|
| 1 PLACE OF DEATH<br>County <i>Somerset Co.</i>            |   | 830   |
| Village or City <i>Mason</i>                              |   | (No.)   |
| 2 FULL NAME <i>Sarah Jervold</i>                          |   |   |
| PERSONAL AND STATISTICAL PARTICULARS                      |   |   |
| 3 SEX <i>Female</i>                                       | 4 COLOR OR RACE <i>Cul</i>  | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word) <i>married</i> |
| 6 DATE OF BIRTH <i>Not known.</i><br>(Month) (Day) (Year) |   |   |
| 7 AGE <i>About 59</i>                                     | 8 OCCUPATION <i>Housework</i>   | 9 If LESS than<br>1 day, hrs.<br>OR min. ?  |
| 10 BIRTHPLACE<br>(State or country) <i>Md</i>             | 11 NAME OF FATHER <i>Don't know</i>   | 12 MAIDEN NAME OF MOTHER <i>Anne Standy</i>   |
| 13 BIRTHPLACE<br>(State or country) <i>Md</i>             | 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <i>Noah Roach</i><br>(Address) <i>Mason</i> |   |
| 15 Filed <i>1/23 1914</i>                                 | 16 PLACE OF BURIAL OR REMOVAL <i>Mt. Pisgah Cemetery</i>  |   |

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *261*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 22*, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Causes for patient was due to*  
*unconsciousness.* that I last saw him alive on *Jan 22*, 1914.and that death occurred on the date stated above, at *5 A.m.*

The CAUSE OF DEATH\* was as follows:

*Cordicase Ophuston*18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ dsWhere was disease contracted,  
if not at place of death?  
Former or usual residence.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 PLACE OF BURIAL OR REMOVAL *Mt. Pisgah Cemetery*DATE OF BURIAL *1-24, 1914*20 UNDERTAKER *Aw Difor*ADDRESS *Mason*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Associated]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coat mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma

"Sarcoma, etc. of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by earabolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

831

County

Somerset

Village or City

Upper Fairmount

## 2 FULL NAME

Hence Johnson

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Black

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

## 6 DATE OF BIRTH

Dont Know, 1  
(Month) (Day) (Year)

## 7 AGE

About 73

yrs. — mos. — ds.

It LESS than  
1 day, .... hrs.  
OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work *Laborer on farm*  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) *—*

9 BIRTHPLACE  
(State or country)

Maryland

Beauchamp Johnson

## PARENTS

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Milcha Maddox*(Address) *Upper Fairmount*

## 15

Filed Jan 19<sup>th</sup> 1914 G. E. Dickinson

Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 264

St. Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 19<sup>th</sup>, 1914

(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on , 191 to , 191

and that death occurred on the date stated above, at 4 A.m.,

The CAUSE OF DEATH\* was as follows:

*Senile Debility  
no Physician in attendance  
Gradually failed*

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. E. Dickinson, M. D.

Jan 19<sup>th</sup> 1914 (Address) Upper Fairmount

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted.

If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Jamesburg Church Yards Jan 20, 1914

20 UNDERTAKER

## ADDRESS

Herbert Wilson Upper Fairmount

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Maidservants* who receive a definite salary), may be entered as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trismia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ictanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|              |
|--------------|
| RECEIVED     |
| FEB 4 1914   |
| BUREAU, V.S. |

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Somerset

832

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 267St.: A Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Dames Quarter (No.)

## 2 FULL NAME

Georgia R Jones

## PERSONAL AND STATISTICAL PARTICULARS

|                |                           |   |
|----------------|---------------------------|---|
| 3 SEX <u>F</u> | 4 COLOR OR RACE <u>B.</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Single</u> |
|----------------|---------------------------|---|

## 6 DATE OF BIRTH

Feb 27, 1912  
(Month) (Day) (Year)

## 7 AGE

1 yrs. 10 mos. 5 ds. If LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country) Md.

## PARENTS

10 NAME OF FATHER William C. Jones11 BIRTHPLACE OF FATHER  
(State or country) Md.12 MAIDEN NAME OF MOTHER Lena Halland13 BIRTHPLACE OF MOTHER  
(State or country) Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William C. Jones(Address) Dames Quarter, Md.

## 15

Filed Jan. 4, 1914 W. S. Kelly.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan. 2, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1914 to Jan. 2, 1914, that I last saw her alive on Jan. 2, 1914, and that death occurred on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. ds.

Contributory Toxæmia  
Secondary

(Duration) yrs. mos. ds.

(Signed) E.P. Simpson, M.D.  
MAR 10 1914 (Address) CHANGE MD.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL  
Dames Quarter, Md. Jan 4, 1914

## 20 UNDERTAKER

ADDRESS  
T. W. Hendry Deals Island  
Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*,

|              |            |
|--------------|------------|
| RECEIVED     | FEB 7 1914 |
| BUREAU, V.S. |            |

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traenia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

833

County SomersetSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 265Village or City Brisfield (No. 189)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Jones

## PERSONAL AND STATISTICAL PARTICULARS

|                 |                              |  |
|-----------------|------------------------------|--|
| 3 SEX <u>M.</u> | 4 COLOR OR RACE <u>Black</u> | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word) <u>Infant</u> |
|-----------------|------------------------------|--|

## 6 DATE OF BIRTH

Jan 23, 1914  
(Month) (Day) (Year)

|                     |        |                       |                                  |
|---------------------|--------|-----------------------|----------------------------------|
| 7 AGE<br>..... yrs. | mos. / | ds.<br>OR..... min. ? | It LESS than<br>1 day,..... hrs. |
|---------------------|--------|-----------------------|----------------------------------|

8 OCCUPATION  
 (a) Trade, profession, or  
particular kind of work.  
 (b) General nature of industry,  
business, or establishment in  
which employed (or employer) I had no physician

9 BIRTHPLACE  
(State or country) Brisfield, Md.

10 NAME OF  
FATHER Edward E. Jones

11 BIRTHPLACE  
OF FATHER  
(State or country) Somerset Co

12 MAIDEN NAME  
OF MOTHER Maggie Harris

13 BIRTHPLACE  
OF MOTHER  
(State or country) Brisfield

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Jones

(Address) Brisfield

15 Filed Jan 25, 1914 E. E. Collins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 25, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191..., to ..... , 191...

that I last saw h. .... alive on ..... , 191...

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH\* was as follows:

I had no physician

(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.

(Signed) E. E. Collins, M. D.

Jan 25, 1914 (Address) Brisfield

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Fisherman Cemetery DATE OF BURIAL Jan 25, 1914

20 UNDERTAKER R. J. St. James ADDRESS Brisfield

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

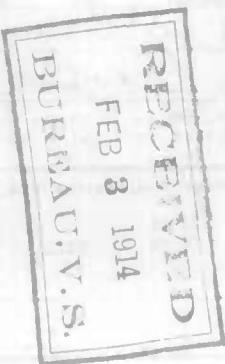
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mosches* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS PROBABLY SUCH, IF IMPOSSIBLE TO DETERMINE DEFINITELY. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH  
County Baltimore

834

Village or City Brown's Ann. (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 268

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant of Wm J Jones

## PERSONAL AND STATISTICAL PARTICULARS

|                   |                              |  |
|-------------------|------------------------------|--|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Black</u> | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word) <u>Single</u> |
|-------------------|------------------------------|--|

|                              |       |                    |
|------------------------------|-------|--------------------|
| 6 DATE OF BIRTH <u>Jan 2</u> |       |                    |
| (Month)                      | (Day) | (Year) <u>1914</u> |

|       |             |               |              |  |
|-------|-------------|---------------|--------------|--|
| 7 AGE | 8 yrs. .... | mos. <u>7</u> | ds. <u>7</u> | If LESS than<br>1 day, ..... hrs.<br>OR ..... min. ? |
|-------|-------------|---------------|--------------|--|

|  |  |
|--|--|
| 8 OCCUPATION<br>(a) Trade, profession, or<br>particular kind of work.....                                    | 9 BIRTHPLACE<br>(State or country) <u>Mo</u> |
| (b) General nature of industry,<br>business, or establishment in<br>which employed (or employer) <u>None</u> |  |

|  |  |
|--|--|
| 10 NAME OF<br>FATHER <u>Wm J Jones</u> | 11 BIRTHPLACE<br>OF FATHER<br>(State or country) <u>Mo</u> |
|--|--|

|  |  |
|--|--|
| 12 MAIDEN NAME<br>OF MOTHER <u>Bess Watson</u> | 13 BIRTHPLACE<br>OF MOTHER<br>(State or country) <u>Mo</u> |
|--|--|

|   |                                   |
|---|-----------------------------------|
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Wm J Jones</u> | (Address) <u>Brown's Annex Mo</u> |
|---|-----------------------------------|

|                              |                    |
|------------------------------|--------------------|
| 15 Filed <u>Jan 9th 1914</u> | <u>G. J. Smith</u> |
|------------------------------|--------------------|

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1914, to 1914,  
that I last saw him alive on 1914,

and that death occurred on the date stated above, at 1914 m.

The CAUSE OF DEATH\* was as follows:

No b. in Albany area, was living  
with his wife & 3 & 4 children  
in judge Cushing's house  
Baltimore on Jan 8 (Duration) yrs. mos. ds.

Contributory Prison  
Secondary Secondary  
(Signed) G. J. Smith (Address) Brown's Annex Mo M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

|  |                                     |
|--|-------------------------------------|
| 19 PLACE OF BURIAL OR REMOVAL <u>Brown's Annex</u> | DATE OF BURIAL <u>Jan 10th 1914</u> |
|--|-------------------------------------|

|                                 |                              |
|---------------------------------|------------------------------|
| 20 UNDERTAKER <u>Wm J Jones</u> | ADDRESS <u>Brown's Annex</u> |
|---------------------------------|------------------------------|

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

### American Public Health

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b), *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Mauser," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; a void use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrphy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telaus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature or the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesmen*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcin-*oma. *Surcoma*, etc., of \_\_\_\_\_ (name origin); "Cap-  
se" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
FEB 3 1914

BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Somerset

836

Village or City Crisfield (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 265

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

W. Henry Nelson

## PERSONAL AND STATISTICAL PARTICULARS

|                   |                              |   |
|-------------------|------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u><br>(Write the word) |
|-------------------|------------------------------|---|

|  |         |       |                    |
|--|---------|-------|--------------------|
| 6 DATE OF BIRTH <u>Sept. 26<sup>th</sup></u> | (Month) | (Day) | (Year) <u>1890</u> |
|--|---------|-------|--------------------|

|                                  |  |
|----------------------------------|--|
| 7 AGE <u>33 yrs 3 mos 13 ds.</u> | If LESS than 1 day, .... hrs.<br>OR min. ? |
|----------------------------------|--|

|  |   |
|--|---|
| 8 OCCUPATION <u>Waterman</u><br>(a) Trade, profession, or particular kind of work. | <u>Working with his father in Oyster Business</u> |
|--|---|

|  |  |
|--|--|
| 9 BIRTHPLACE<br>(State or country) <u>Maryland</u> |  |
|--|--|

|   |  |
|---|--|
| 10 NAME OF FATHER <u>Jas. H. Nelson</u> |  |
|---|--|

|   |  |
|---|--|
| 11 BIRTHPLACE OF FATHER<br>(State or country) <u>Maryland</u> |  |
|---|--|

|  |  |
|--|--|
| 12 MAIDEN NAME OF MOTHER <u>Josephine Lawson</u> |  |
|--|--|

|   |  |
|---|--|
| 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>Maryland</u> |  |
|---|--|

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Josephine Nelson

(Address) Crisfield, Md.

15 Filed Jan 11, 1914 C. E. Collins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 8<sup>th</sup>

(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Jan 6, 1914, to Jan 8, 1914, that I last saw him alive on Jan 8, 1914,

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH was as follows:

Cardiac ViolationPulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Mrs. George Brown, M. D.

Jan 8, 1914 (Address) Crisfield, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ in the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL Ashley Cemetery

DATE OF BURIAL Jan. 13<sup>th</sup>, 1914

20 UNDERTAKER J. L. Lawson

ADDRESS Crisfield, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

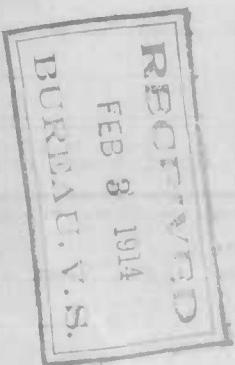
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin: "Cancer") is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Deals Island 837  
County Wenona Someret Co.

Village or City Deals Island (No. 136)

2 FULL NAME William Parkinson

| PERSONAL AND STATISTICAL PARTICULARS |                          |   |
|--------------------------------------|--------------------------|---|
| 3 SEX <u>M</u>                       | 4 COLOR OR RACE <u>W</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Single</u> |

6 DATE OF BIRTH Aug 7 1913  
(Month) (Day) (Year)

7 AGE 9 yrs. 9 mos. 0 ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work \_\_\_\_\_  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) Md.

10 NAME OF FATHER Sammy Parkinson

11 BIRTHPLACE OF FATHER  
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mannie White

13 BIRTHPLACE OF MOTHER  
(State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mannie Parkinson

(Address) Wenona Md.

15 Filed Jan 20 1914 Ges Bostander

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 268

St. \_\_\_\_\_ Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 20, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan 16, 1914, to Jan 19, 1914,  
that I last saw him alive on Jan 19, 1914,  
and that death occurred on the date stated above, at 1 a.m.  
The CAUSE OF DEATH\* was as follows:

Gastric Enteritis

(Duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory Exhaustion & Dehydration  
Secondary

(Duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) E.P. Simpson, M. D.

Jan 20, 1914 (Address) Chambley Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.  
Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Deals Island DATE OF BURIAL Jan 20, 1914

20 UNDERTAKER Led. Hendy ADDRESS Deals Island

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocer*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maugger," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma

oma

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dobility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by earbolite acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 8 1914

BUREAU U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Somerset

838

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Crisfield (No. \_\_\_\_\_)*(Signature)*County Jersey  
2 FULL NAME Robert Paterson

## PERSONAL AND STATISTICAL PARTICULARS

|                   |                              |   |
|-------------------|------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>negro</u> | 5 SINGLE, MARRIED, WIDOWED; OR DIVORCED<br>(Write the word) <u>Single</u> |
|-------------------|------------------------------|---|

6 DATE OF BIRTH June 27, 1877  
(Month) (Day) (Year)

7 AGE 36 yrs. 6 mos. 13 ds. If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

8 OCCUPATION  
 (a) Trade, profession, or  
particular kind of work. Oyster Opener  
 (b) General nature of industry,  
business, or establishment in  
which employed (or employer) Oyster packing

9 BIRTHPLACE  
(State or country) Md.

10 NAME OF  
FATHER Frank Paterson

11 BIRTHPLACE  
OF FATHER  
(State or country) Md.

12 MAIDEN NAME  
OF MOTHER Frankie Brinkley

13 BIRTHPLACE  
OF MOTHER  
(State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rachel Marshall

(Address) Crisfield Md.

15 Filed Jan 13, 1914 C. E. Collins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 10, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Jan. 10, 1914, to Jan. 10, 1914,

that I last saw him alive on Jan. 10, 1914,  
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH\* was as follows:

Acute indigestion  
The mother came home  
nothing to eat  
M.P. (Duration) yrs. 1/2 mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) W. J. Barkley, M. D.  
Jan. 11, 1914 (Address) 309 W. Md. Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Garrison DATE OF BURIAL Jan 13, 1914

20 UNDERTAKER R. J. Adams ADDRESS Crisfield

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hausekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Pneumonitis* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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RECEIVED

FEB 3 1914

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Somerset

839

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 262

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Westover (No.)2 FULL NAME Robert H. Powell

## PERSONAL AND STATISTICAL PARTICULARS

|                   |                              |   |
|-------------------|------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OR DIVORCED<br>(Write the word) <u>MARRIED</u> |
|-------------------|------------------------------|---|

|                            |          |               |
|----------------------------|----------|---------------|
| 6 DATE OF BIRTH <u>Nov</u> | <u>8</u> | , <u>1834</u> |
|                            | (Month)  | (Day)         |
|                            |          | (Year)        |

|                 |               |                |              |   |
|-----------------|---------------|----------------|--------------|---|
| 7 AGE <u>79</u> | yrs. <u>1</u> | mos. <u>26</u> | ds. <u>0</u> | If LESS than<br>1 day, .... hrs.<br>OR ..... min. ? |
|-----------------|---------------|----------------|--------------|---|

|  |
|--|
| 8 OCCUPATION<br>(a) Trade, profession, or<br>particular kind of work <u>Carpenter Farmer</u>             |
| (b) General nature of industry,<br>business, or establishment in<br>which employed (or employer) <u></u> |

|  |
|--|
| 9 BIRTHPLACE<br>(State or country) <u>Worcester Co</u> |
|--|

|  |
|--|
| 10 NAME OF<br>FATHER <u>David Henry Powell</u> |
|--|

|   |
|---|
| 11 BIRTHPLACE<br>OF FATHER<br>(State or country) <u>Somerset Co</u> |
|---|

|   |
|---|
| 12 MAIDEN NAME<br>OF MOTHER <u>Ann Maria Taylor</u> |
|---|

|   |
|---|
| 13 BIRTHPLACE<br>OF MOTHER<br>(State or country) <u>Somerset Co</u> |
|---|

|  |
|--|
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Henry J. Powell</u> |
|--|

|                               |
|-------------------------------|
| (Address) <u>Westover, Md</u> |
|-------------------------------|

|   |
|---|
| 15 Filed <u>Jan 30, 1914</u> <u>C. Powell</u> |
|---|

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 4, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1913, to Dec 20, 1913,  
that I last saw him alive on Dec 20, 1913,

and that death occurred on the date stated above, at 1 P.M..  
The CAUSE OF DEATH\* was as follows:

Exhaustion & Heart

Faileuse

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) 1/30, 1914 J. Ballou, M.D.  
(Address) Monroe Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Bethelbath DATE OF BURIAL Jan 5, 1914

20 UNDERTAKER Sorenson Bros. Poconos ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Hunter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc. of ..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 8 1914

BUREAU, V. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Somerset Co

840

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 261

Village or City Morion (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME Isaac H. Price,

## PERSONAL AND STATISTICAL PARTICULARS

|            |                       |   |
|------------|-----------------------|---|
| 3 SEX Male | 4 COLOR OR RACE white | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed |
|------------|-----------------------|---|

## 6 DATE OF BIRTH

dont know, 1840  
(Month) (Day) (Year)

## 7 AGE

73 dont know It LESS than  
yrs. mos. ds. OR min. ?  
1 day, hrs.

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE  
(State or country)

Somerset Co.,

Robert Price

Maryland

Mary A. Riggan

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Price

(Address) Morion Md

15 Filed 1/13 1914 F. J. Adams

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 12, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1914, to Jan 12, 1914,

that I last saw him alive on Jan 11, 1914,

and that death occurred on the date stated above, at 12 noon.

The CAUSE OF DEATH\* was as follows:

Angina Pectoris

3 days (Duration) yrs. mos. ds.

Contributory age Secondary

(Duration) yrs. mos. ds.

(Signed) Lazarus, M. D.

1-13, 1914 (Address) Morion Md

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Rehobeth

DATE OF BURIAL 1-14, 1914

20 UNDERTAKER Jacob Stevenson

ADDRESS Socoweb

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

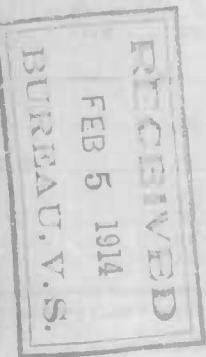
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lung*, *meninges*, *peritonaeum*, etc., *Carcinoma*,

oma, *Sarcoma*, etc. of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—*homicide*; *Poisoned by carbolic acid*—*probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *spasis*, *ictus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Somerset

841

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 261Village or City Marrow (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Amelia Scoville

## PERSONAL AND STATISTICAL PARTICULARS

|                     |                                |  |
|---------------------|--------------------------------|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>OLDWIDOWED<br>(Write the word) <u>married</u> |
|---------------------|--------------------------------|--|

## 6 DATE OF BIRTH

January, 1861  
(Month) (Day) (Year)

## 7 AGE

53 yrs. .... mos. .... ds. If LESS than  
1 day, .... hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work Hauswif  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Somerset Co Md

10 NAME OF FATHER Nathan Turpin

11 BIRTHPLACE OF FATHER  
(State or country) Somerset Co Md

12 MAIDEN NAME OF MOTHER Henri — not known

13 BIRTHPLACE OF MOTHER  
(State or country) Somerset Co Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Issue Scoville  
(Address) Marrow Md

15 Filed 1/20 1914 J. J. Adams

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 18, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sgt 1, 1912, to Jan 18, 1914,

that I last saw her alive on Jan 10, 1914

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH\* was as follows:

Cordic Ischemia  
sugestotis Pneumonia  
GHT

(Duration) .... yrs. .... mos. .... ds.

Contributory Gorinosa frater  
Secondary

(Duration) 2 yrs. .... mos. .... ds.

(Signed) George Courtney, M. D.  
Jan 19, 1914 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Pis Cemetery

DATE OF BURIAL 1-20, 1914

20 UNDERTAKER Acodikian

ADDRESS Marrow

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

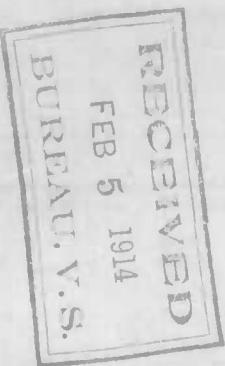
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e.g., *Farmer or Planter*, *Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Contractor, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Tuberous pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*,

*oma, Sarcoma, etc., of..... (name origin); "Cancer"* is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic arteriolar heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state *MEANS OF INJURY* and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *syrinx, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Somerset

842

Village or City Crisfield (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 263St. \_\_\_\_\_ Ward Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sarah F. Somers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE White 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) Single

6 DATE OF BIRTH

Apr 22, 1840  
(Month) (Day) (Year)

7 AGE

73 yrs 9 mos 8 ds. If LESS than  
1 day, \_\_\_\_\_. hrs.  
OR \_\_\_\_\_. min. ?

8 OCCUPATION

- (a) Trade, profession, or  
particular kind of work Housewife  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER Jesse Somers11 BIRTHPLACE  
OF FATHER  
(State or country) Somerset Co. Md.12 MAIDEN NAME  
OF MOTHER Jane Adams13 BIRTHPLACE  
OF MOTHER  
(State or country) Somerset Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pettymon Somers(Address) Crisfield Md.

15

Filed Jan 31, 1914

C. C. Collins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 30

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1914 to Jan 30, 1914,that I last saw her alive on Jan 30, 1914,and that death occurred on the date stated above, at H.P. m.

The CAUSE OF DEATH\* was as follows:

Anemia Pectoris

(Duration) yrs. mos. ds.

Contributory Pregnancy

Secondary (Duration) yrs. mos. ds.

(Signed) W. F. Haall, M. D. (Address) Crisfield Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_. yrs. \_\_\_\_\_. mos. \_\_\_\_\_. ds. In the State \_\_\_\_\_. yrs. \_\_\_\_\_. mos. \_\_\_\_\_. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Paul's CemeteryDATE OF BURIAL Feb 1, 191420 UNDERTAKER R. J. AdamsADDRESS Crisfield

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

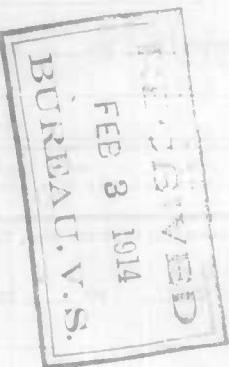
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "*Anæmia*," "*Anæmia*" (merely symptomatic), "*Atrophy*," "*collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("Con genital," "*Senile*," etc.), "*Dropsey*," "*Exhaustion*," "*Heart failure*," "*Hæmorrhage*," "*Inanition*," "*Malaria*," "*Old Age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## MARGIN RESERVED FOR BINDING

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|  |                              |   |
|--|------------------------------|---|
| 1 PLACE OF DEATH   |                              | 843   |
| County <u>Somerset</u>   |                              | <u>79</u>   |
| Village or City <u>Deel Island</u> (No. <u>134</u> )   |                              |   |
| 2 FULL NAME <u>William Stein</u>   |                              |   |
| PERSONAL AND STATISTICAL PARTICULARS   |                              |   |
| 3 SEX <u>Male</u>  | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u><br><small>(Write the word)</small> |
| 6 DATE OF BIRTH <u>March 4</u>   |                              | Month <u>March</u> Day <u>4<sup>th</sup></u> , Year <u>1862</u>                           |
| 7 AGE <u>57</u>  |                              | If LESS than<br>1 day, <u>9</u> hrs.<br>OR <u>min. ?</u>                                  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Cystitioner</u>   |                              |   |
| (b) General nature of industry, business, or establishment in which employed (or employer) <u>Crabber</u>                      |                              |   |
| 9 BIRTHPLACE<br>(State or country) <u>Germany</u>  |                              |   |
| 10 NAME OF FATHER <u>Inkisson</u>  |                              |   |
| 11 BIRTHPLACE OF FATHER<br>(State or country) <u>Germany</u>   |                              |   |
| 12 MAIDEN NAME OF MOTHER <u>Louise Ella</u>  |                              |   |
| 13 BIRTHPLACE OF MOTHER<br>(State or country) <u>Germany</u>   |                              |   |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Mrs Virginia Stein</u><br>(Address) <u>Deel's Island Md</u> |                              |   |
| 15 Filed <u>Jan 8<sup>th</sup> 1914</u>  | Georg B. Horner              | REGISTRAR   |

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 268

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 4<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 15<sup>th</sup> 1913 to Jan 4<sup>th</sup>, 1914

that I last saw him alive on Jan 4<sup>th</sup>, 1914

and that death occurred on the date stated above, at Deel's Island m.

The CAUSE OF DEATH\* was as follows:

Kidney heart disease

(Duration) unknown yrs. mos. ds.

Contributory Gout Primary Arthritis  
Secondary unknown

(Duration) unknown yrs. mos. ds.

(Signed) H. Alexander, M. D.  
(Address) Deel's Island

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Deel's Island Md DATE OF BURIAL Jan 8<sup>th</sup>, 1914

20 UNDERTAKER Geo. B. Horner ADDRESS Deel's Island Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

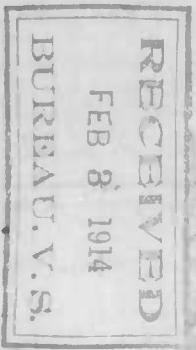
[Approved by U. S. Census and American Public Health Association.]

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## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH  
County Somerset

844

Village or City Champ, Md. (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 760St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ruth Elizabeth Wallace

## PERSONAL AND STATISTICAL PARTICULARS

|                     |                              |  |
|---------------------|------------------------------|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE,<br>MARRIED,<br>WIDOWED,<br>DIVORCED<br>(Write the word) <u>Cleid</u> |
|---------------------|------------------------------|--|

6 DATE OF BIRTH February 26, 1913  
(Month) (Day) (Year)

7 AGE yrs. 10 mos. 27 ds.  
If LESS than  
1 day, ....hrs.  
OR min.?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work.  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) Champ, Md.

10 NAME OF  
FATHER Lewis S Wallace

11 BIRTHPLACE  
OF FATHER  
(State or country) Oriole Md

12 MAIDEN NAME  
OF MOTHER Martha E. Breamer

13 BIRTHPLACE  
OF MOTHER  
(State or country) Dorchester Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis S. Wallace

(Address) Oriole Md

15 Filed 1/23, 1914 J. Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 22, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 16, 1914, to Jan 22, 1914,  
that I last saw her alive on Jan 22, 1914,

and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary Pneumonia

(Duration) yrs. mos. ds.

(Signed) John & Ruby, M.D. Oriole, Md.

(Address) Jan 22, 1914

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. mos. ds. In the State \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL Oriole DATE OF BURIAL 1/23, 1914

20 UNDERTAKER H. Wilson ADDRESS Thomas Junius

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Somerset

845

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 268St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Deals Island (No. 103)

## 2 FULL NAME

Louise E. Webster

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

F.

## 4 COLOR OR RACE

W.

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Widow

## 6 DATE OF BIRTH

May 8, 1832  
(Month) (Day) (Year)

## 7 AGE

81 yrs 7 mos 25 ds.

If LESS than  
1 day.....hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Housewife

## 9 BIRTHPLACE

(State or country)

Md.

## PARENTS

## 10 NAME OF FATHER

Noah Kelly

## 11 BIRTHPLACE OF FATHER

(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Elizabeth Daniel

## 13 BIRTHPLACE OF MOTHER

(State or country)

Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lorena Webster

(Address)

Deals Island

## 15

Fled Jan 4, 1914 geo. B. Horner

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Jan 2, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Dec. 30, 1913, to Jan 2, 1914.

that I last saw her alive on Jan 2, 1914  
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

Gastritis, Acute

(Duration) yrs. mos. ds.

Contributory Secondary Derm. Delirium

(Duration) yrs. mos. ds.

(Signed) E.P. Simpson, M.D.  
MAR 26 1914 (Address) CHANGE MD

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or osoal residence

## 19 PLACE OF BURIAL OR REMOVAL

Deals Island DATE OF BURIAL Jan 4th, 1914

## 20 UNDERTAKER

Leonard J. Webster ADDRESS Deals Island

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Grouper"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchoneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

BUREAU, V. S.

FEB 8 1914

sent for sig. or name from

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc., State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *celitus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
MAR 28 1914  
BUREAU, V. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH  
County Somerset

846

Village or City Marietta, Md. (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 265St. Ward

*G*  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Oliver Wallace Whittington

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE;  
MARRIED,  
WIDOWED,  
OR DIVORCED  
*(Write the word)* Married

6 DATE OF BIRTH about  
unknown, 1873  
(Month) (Day) (Year)

7 AGE 39 —  
 yrs. — mos. — ds.  
 If LESS than  
 1 day, \_\_\_\_ hrs.  
 OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
 particular kind of work... Farmer  
(b) General nature of industry,  
 business, or establishment in  
 which employed (or employer) Farming

9 BIRTHPLACE  
(State or country) Md.

10 NAME OF  
FATHER Unknown

11 BIRTHPLACE  
OF FATHER  
(State or country) Unknown

12 MAIDEN NAME  
OF MOTHER Unknown

13 BIRTHPLACE  
OF MOTHER  
(State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Whittington

(Address) Marietta, Sta. Md.

15 Filed Jan. 26, 1914 Dr. Gallister

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*G* Jan. 24, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1914, to Jan. 24, 1914,  
that I last saw him alive on Jan. 22, 1914,

and that death occurred on the date stated above, at 4:45 A.M.

The CAUSE OF DEATH\* was as follows:

Bronchitis - pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Doratology) yrs. mos. ds.

(Signed) W. J. Barker, M. D.  
Jan. 24, 1914 (Address) 309 W. 2d. Ave.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*G* near Marion, Sta. Jan. 25, 1914

20 UNDERTAKER ADDRESS

*G* P. J. Adams Grisfield

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dribility" ("Con genital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be retained before the certificate is permanent.

RECEIVED

FEB 3 1914

BUREAU, V.S.

RECEIVED

FEB 8 1914

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County. *Baltimore*

847

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *268*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City *Baltimore Avenue* (No.)2 FULL NAME *John Wilson*

## PERSONAL AND STATISTICAL PARTICULARS

|                   |                                |  |
|-------------------|--------------------------------|--|
| 3 SEX <i>Male</i> | 4 COLOR OR RACE <i>Colored</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Married</i><br>(Write the word) |
|-------------------|--------------------------------|--|

6 DATE OF BIRTH

*Septt* (Month) *1860* (Day) (Year)

7 AGE

*53* yrs. — mos. — ds. OR min. ?

it LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work *Spanner*  
 (b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE  
(State or country)*Ted*

PARENTS

10 NAME OF FATHER

*Lewis Wilson*11 BIRTHPLACE OF FATHER  
(State or country)*Ted.*

12 MAIDEN NAME OF MOTHER

*Mary Catherine*13 BIRTHPLACE OF MOTHER  
(State or country)*Ted*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*John Wilson*

(Address)

*Baltimore Avenue Ted.*

15

Filed *July 28*

, 1914

*J. J. Smith*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan 28*, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*July 19, 1913*, to *Nov 28*, 1913,  
that I last saw him alive on *Nov 28*, 1913,

and that death occurred on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Spontaneous*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) *John J. Dunn*, M. D.*1/28, 1914* (Address) *Baltimore Avenue Ted.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

*At home* DATE OF BURIAL *1/29, 1914*

20 UNDERTAKER

*James J. Dunn* ADDRESS *Baltimore Avenue*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*oma, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic catarrhal heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *collapse*; *Convulsions*; *Debility*; "Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

MAY 5 1914

BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

V. S. No. 1.

## 1 PLACE OF DEATH

County *Somerset*

848

Village or City *Not known*2 FULL NAME *William A Wilson*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) *Married*

6 DATE OF BIRTH *Dec 6*(Month) (Day) (Year) *(Month) (Day) (Year)*7 AGE *63 yrs. 1 mos. 19 ds.*

If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION *Tanner*

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) *Somerset Co*10 NAME OF FATHER *Lewis Wilson*11 BIRTHPLACE OF FATHER  
(State or country) *Md*12 MAIDEN NAME OF MOTHER *Rachel Bradley*13 BIRTHPLACE OF MOTHER  
(State or country) *Md*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. A. Wilson Jr*Address *Princes Anne Md*

## 15

Filed *Jan 25 1914*

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *263*

St; Ward)

[if death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 25, 1914*

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Jan 1, 1914*, to *Jan 25, 1914*,  
that I last saw him alive on *Jan 25, 1914*,  
and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH\* was as follows:

*Obstruction of the descending colon*

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. H. Barnes*, M.D.Jan 25, 1914 (Address) *Princes Anne Md*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

*Not known* *Princes Anne Md* Jan 26, 1914

## 20 UNDERTAKER

ADDRESS  
*W. A. Wilson Bros* *Princes Anne Md*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.<sup>1</sup>

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*oma, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 d.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 4 1914

BUREAU V.S.